APPLICATION FOR HEALTH FACILITY ADMINISTRATOR PROVISIONAL LICENSE

$100 FEE REQUIRED

Health Professions Bureau
402 W. Washington St., Room W066
Indianapolis, Indiana 46204
Telephone number: (317) 234-2051
Email: hpb6@hpb.state.in.us

*** Your Social Security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.**

Application fee
Date fee paid (month, day year)
Receipt number

Issuance Date (month, day year)
Provisional license number

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (last, first, middle, maiden)	
Social Security number*	E-mail Address
Address (number and street or Rural Route)	
City, state, ZIP code	
Telephone number (daytime)	
Birth date	
Birthplace	

WORK EXPERIENCE

You *must* have at least two (2) years of administrative experience in a licensed health facility to qualify for a provisional license [840 IAC 1-1-14 (a)]. **Please attach a complete resume documenting your administrative experience.** Include your employer, position, type of business, period of time worked, duties, type of facility (SNF, ICF, etc.) and number of beds in the facility. The provisional license can only be used in the licensed health facility that is specified on page three (3) of this application.

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, including all related details. Describe the event including location, date and disposition. If malpractice, provide name of plaintiff. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? Yes _____ No _____

2. Have you ever been denied licensure, registration or certification in any state (including Indiana) or country? Yes _____ No _____

3. Are you being treated for drugs or alcohol abuse? Yes _____ No _____

4. Have you ever been charged with drug addiction? Yes _____ No _____

5. Have you ever been convicted of, plead guilty to nolo contendre to any offense, misdemeanor or felony in any state? (Except for minor violations of traffic resulting in fines) Yes _____ No _____

6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended, or subjected to any restrictions, probation or other type of discipline or limitations? Yes _____ No _____

7. Have you ever been admonished, censored, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? Yes _____ No _____

8. Have you ever had a malpractice judgement against you or settled any malpractice action? Yes _____ No _____

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant Date (month, day, year)

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Indiana Health Professions Bureau any file, documents, records or other information pertaining to the undersigned requested by the Bureau, or any of its authorized representatives in connection with the processing of my application for a health facility administrators provisional license.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Indiana Health Professions Bureau to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations and institutions any information which is material to my application and I hereby specifically release the Bureau and Board from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

Signature of applicant Date (month, day, year)

THE FOLLOWING MUST BE COMPLETED BY THE HEALTH FACILITY OWNER
OR AN OFFICER OF THE FACILITY'S BOARD OF DIRECTORS

This is a request for a provisional license as set out in IC 25-19-1-3(b), which states:

(b) The board may issue a provisional license for a single period not to exceed six (6) months for the purpose of enabling a qualified individual to fill a health facility administrator position that has been ***unexpectedly vacated****. Before an individual is issued a provisional license, the individual must fulfill the requirements in subdivision (a)(1) in addition to complying with other standards and rules established by the board.*

Please attach a *detailed* explanation of the reason(s) this provisional license is being requested. This information *must* be included with the application for the Board to consider your request.

Name of prospective individual:

Name of health facility:

Facility address:

City, state, ZIP code

Facility telephone number:

Number of beds in facility:

Type or level of care provided:

VERIFICATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of Officer Date (month, day, year)

Title